UNITED STATES DISTRICT COURT

DISTRICT OF MASSACHUSETTS

NO. 01CV12257-PBS

In re: PHARMACEUTICAL)
INDUSTRY AVERAGE WHOLESALE)
PRICE LITIGATION)
)
THIS DOCUMENT RELATES TO:)
ALL ACTIONS)

DEPOSITION of STEVEN J. FOX, called as a witness by and on behalf of the Johnson & Johnson, pursuant to the applicable provisions of the Federal Rules of Civil Procedure, before P. Jodi Ohnemus, Notary Public, Certified Shorthand Reporter, Certified Realtime Reporter, and Registered Merit Reporter, within and for the Commonwealth of Massachusetts, at the offices of Robins, Kaplan, Miller & Ciresi, L.L.P., 800 Huntington Avenue, Boston, Massachusetts, on Wednesday, 8 March, 2006, commencing at 9:35 a.m.

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PROCEEDINGS

STEVEN J. FOX,
having first been duly sworn, testified as follows to direct interrogatories

BY MR. MANGI:

Q. Mr. Fox, my name is Adeel Mangi. I represent Johnson & Johnson at this litigation. Have you ever been deposed before?

A. I have.

Q. And how many times have you been deposed?

A. Once.

Q. When was that?

A. 2005.

Q. What was the context for that deposition?

A. Thomas litigation.

Q. Now, what were the issues at play in the Thomas litigation?

A. I was being deposed based on my role in managing the provider network for Blue Cross Blue Shield.

Q. Do you have an understanding as to what the Thomas case was about?

A. Generally.

Q. Okay. Can you describe for me your understanding of the Thomas litigation.

A. My understanding is that it's essentially brought forward a class action lawsuit. A group of physicians in Florida named a lot of health plans across the country, named Blue Cross plans across the country, and we were one plan, so we were also named as part of the class, and it had to do with how transparency of reimbursement and communication of -- reimbursement essentially.

Q. What issues specifically were the plaintiffs in that case raising as regards transparency and communication of reimbursement?

MR. COCO: Objection.

A. I don't know how -- I don't know what they were raising in general with the case. I mean, most of my testimony had to do with how was our network structured. How did we communicate to physicians. All of my testimony essentially is around my role, how we work with physicians, how I communicate with physicians. And most of what we did and do at Blue Cross Blue Shield is -- didn't -- my view, it didn't apply to the case.

Q. Why do you say that?

A. Again, based on what we do, we communicate with physicians, we work with our physicians. It just didn't seem like a lot of what they were talking about in the case applied to us.

Q. Well, I'm trying to understand what you mean by that. What are the things that you thought they were talking about that didn't apply to you?

A. Do you tell physicians what the fee schedules are? Do you communicate with physicians? Are your policies and procedures available, and things like that?

Q. Well, let's take the first of those, do

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you tell physicians what the fee schedules are? Why did you think that issue does not apply to BCBS of Massachusetts?
A. Because we -- we do. We disclose our reimbursement rates to our physicians. My understanding is that some of the other defendants in that case -- maybe they did not. I -- I don't know. Can't speak for them.
Q. The second issue that was raised was how do you communicate with physicians?
A. Uh-huh.
Q. Again, why did you think that didn't apply to BCBS of Massachusetts?
A. I mean, we do -- we do a lot of -- we do a lot of communication around lots of things. Again, my understanding of the case, a lot of the things that were mentioned just didn't apply.
Q. Now, other than communicating generally and communicating fee schedules, were there other issues raised in that litigation that you recall?
A. Not that I recall. Primarily that.
Q. Do you know what the eventual resolution

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was as regards BCBS of Massachusetts in the Thomas litigation?
A. I don't.
Q. Do you know whether the case was settled or not?
A. I don't believe the case has been settled.
Q. You understand the case is ongoing?
A. My understanding is that it is.
Q. Now, the two issues you raised, first being telling physicians what the fee schedules are, does BCBS append fee schedules to all contracts that it enters into with physicians?
A. When you say, "BCBS," are you talking about BCBS of Mass. or --
Q. Yes.
A. -- in general?
Q. You're right. I should -- I should --
A. Okay.
Q. -- rephrase that. Does BCBS of Massachusetts append fee schedules to all contracts that it enters into with physicians?

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A. Does it append fee schedules to all contracts it enters into? No. Our fee schedule -- - no, the answer is no.
Q. When BCBS of Massachusetts enters into a contract with a physician, is the physician informed in any way what the fee schedule rates are?
A. Usually, yes.
Q. Okay. How is that communication made?
A. Could be a couple of ways. I mean, typically, if it's a physician who's brand new, never -- just out of medical school, we will essentially give them what we call a sample fee schedule. It's the top -- I believe it's 100 codes that that physician specialty bills, and we will provide that to them, along with the appropriate contract and application.
We don't wait for them to ask for it. We typically give it to them. There -- there can be also physicians can just question us. There may be codes outside of that that they want to know. So, they'll ask us or they'll give us a

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list of codes, and we'll give them what the reimbursement is for those codes.
Q. Now, what about a physician who's not typically -- who's not fresh out of medical school but was not previously part of the network? Would such a physician, signing a contract with BCBS of Massachusetts for the first time, also get a copy -- a copy of the sample fee schedule?
A. I mean, they should. I've not ever run across a physician who wants to come in our network that doesn't ask about fees. So, one way or the other, they -- they either have it -- they ask for it. That's typically what happens. We -- I've not ever seen a physician sign a contract and have no understanding of fees.
Q. So, other -- the only physicians who are given the sample fee schedule as a matter of course without them asking for it are new doctors who are fresh out of medical school, is that right?
MR. COCO: Objection.
A. I didn't say that.

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Q. Okay. Perhaps you can help me. Perhaps I misunderstood. I understood you to say that the doctors who are fresh out of medical school are given the fee schedule as a matter of course. Whereas, other doctors are not given it as a matter of course by BCBS, but typically will ask for it, so will receive it. What -- did I misunderstand any part of that?

MR. COCO: Objection.

A. Typically, again, I think what I said is typically, a physician who is -- is coming into -- brand new, typically, as a matter of course we will give them the fee schedule. All of our contracts allow physicians to get the fees upon request. They ask for it; they get it. So, we could take the position that we will just wait and ask them all to ask for it, but the way we do business is we will -- we'll provide it if we know that this is somebody who probably doesn't know it.

A physician who is already here or new to the area but not a "new physician," again, same

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standard would apply. The contract says you get the fee schedule upon request. But, again, we'll make it available. We don't -- so, I think that's -- I think that's what I said.

Q. So, the fee schedules are available to all physicians on request, and for new physicians, you go an extra mile and give them a copy regardless.

MR. COCO: Objection.

Q. Is that correct?

A. Typically, but it's not -- again, the contract says -- technically, the contract -- I don't have to give them anything. I can just give them a contract and application. We will typically, for a physician coming in, provide that. But I -- certainly not in all cases.

Q. Okay. So, it's -- it's not a rule or a standard policy, but it's a frequent practice.

MR. COCO: Objection.

A. I didn't say frequent. I just said typically we would do it.

Q. Okay. Are you -- are you making a

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distinction between something that happens frequently and something that happens typically?

A. Yeah, I am.

Q. Okay. What is the distinction that you're drawing there?

A. Well, frequently, to me, means it's a general business practice, that we do it more oftentimes than we not. Typically means, to me, that we -- we do it, but we not -- it's not a standard practice. We don't do it all the time.

Q. Okay. I think I understand the distinction you're trying to draw there. Now, the other issue that you mentioned from the Thomas litigation was communicating with physicians, and you said you did a lot of communications around a lot of things. What sort of communications were you referring to there?

MR. COCO: Objection.

A. Everything that we produce out of Blue Cross that goes to a physician comes out of my area. We communicate about a lot of things.

Q. All right. Could you give me some

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examples.

A. We send newsletters. We send product updates. Things like that.

Q. Now, are there opportunities for physicians to communicate to you, as opposed to newsletters and product updates that you're sending to them?

A. Sure.

Q. Okay. Now, I assume they can write or call your department. That's one option, right?

A. Sure. Yes.

Q. Other than them calling or writing, are there any other avenues open to them to raise any issues or concerns with BCBS of Massachusetts?

A. You said the -- you said, "the department." When you say, "the department," what do you mean by, "the department"?

Q. Provider relations.

A. Individuals in the department or the department as provider relations, 'cause I'm -- I make a distinction.

Q. Okay. What's the distinction that

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you're making there?
A. Because we have no official -- there is no mailbox title "provider relation," so mail doesn't come into a provider relations mailbox. Physicians, if they're going to write, will either write directly to an individual or they'll write to me.
Q. Okay. Well, let me -- let me rephrase the question then. If a physician wishes to communicate a concern or a question to BCBS of Massachusetts --
A. Right.
Q. -- other than writing or calling, what other avenues of communication are available to them?
A. Meetings.
Q. Anything else?
A. I guess electronic -- e-mail.
Q. Anything else?
A. Not that I'm aware of.
Q. Okay. Is there any formalized system of regular meetings, or would these be on an ad hoc

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basis?
MR. COCO: Objection.
A. With me -- with us, it's ad hoc.
Q. Are there any -- is there a regular schedule of meetings with provider organizations, if not with individual providers?
MR. COCO: Objection.
A. Say that again.
Q. Sure. Well, there are certain groups that represent providers, such as MASCO, for example, or the Mass Medical Society, right?
A. (Witness nods.)
Q. You have to answer verbally so the reporter can take it down.
A. Yes.
Q. Now, I understand that there are no formal recurring meetings with individual physicians. Those are ad hoc, right, as we just discussed?
MR. COCO: Objection.
A. Yes.
Q. My question is, with these societies

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like MASCO, Mass. Medical Society, and other provider organizations like them, does BCBS of Massachusetts have regular ongoing meetings with them?
MR. COCO: Objection.
A. No.
Q. So, those are also on an ad hoc basis as issues come up?
A. Yes, ad hoc.
Q. How about -- withdraw that. Does BCBS of Massachusetts conduct any advisory boards with -- including physicians?
MR. COCO: Objection.
A. There -- there is an advisory council, a Physician Advisory Council.
Q. What is the Physician Advisory Council?
A. It's a group of physician leaders pulled together probably three times a year, really through the medical side of our house, our medical directors and meeting to -- just to essentially have a dialog -- physician relations.
Q. Who's in charge of that process from

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BCBS of Massachusetts?
A. The Physician Advisory Council, that would be Dr. John Fallon.
Q. And he's the chief medical officer, right?
A. He's the chief physician executive.
Q. Now, I'd like to explore that a bit more in a minute, but going back to the practices we discussed with regard to disclosure of fee schedules, how long have those been BCBS of Massachusetts' practices?
MR. COCO: Objection.
A. I don't know how long. I can only tell you that we've been doing it since -- since I've been there, so --
Q. And how long is that?
A. 15 years.
Q. Now, the Physician Advisory Council, how many doctors are on that council?
A. I don't know.
Q. Do you know if it's more than ten or less than ten?

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A. I don't know.
Q. Okay. Do you know how many people from BCBS of Massachusetts are on that council?
A. On the council?
Q. Right.
A. None. It's external.
Q. Okay. So, it's -- the council itself is entirely made up of outside physicians.
A. Yes.
Q. When they -- when that council meets -- withdraw that. This council is something that's been created by BCBS of Massachusetts, right?
MR. COCO: Objection.
A. Created? It's a meeting that we've had for as long as I can remember.
Q. Okay. Let me try and rephrase it. It's not intended to be a trick question.
A. Sure.
Q. I'm trying to understand whether this is an organization that exists independent of BCBS of Massachusetts --
A. Oh.

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Q. -- or is it a group that BCBS of Massachusetts has brought together?
A. No. No. It's a group that we've -- Blue Cross Blue Shield of Massachusetts has brought together.
Q. Okay.
A. We have lots of meetings with lots of physicians in our role as a health insurer. This is one of them.
Q. Now, when did BCBS of Massachusetts bring this group together for the first time?
A. I don't know. Like I said, it's been around for -- in different forms and led by different individuals -- for many years.
Q. When's the first time you're aware of this council or one of its predecessors being in existence?
A. Again, in my whole career, there has been this or other meetings that have occurred. So, 15 years. Not all named the same thing, but --
Q. Okay. Do you recall some of the

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previous names that the Physician Advisory Council went by?
A. Physician Advisory Board. I can't remember any others.
Q. Other than Dr. John Fallon, do you know of anyone else from BCBS of Massachusetts who's involved in working with the Physician Advisory Council?
A. Prior to Doctor Fallon, it would have been Dr. Jim Fanale.
Q. And who is Doctor -- could you spell the name for the record, please.
A. Dr. Jim Fanale.
Q. Oh.
A. F-a-n-a-l-e.
Q. And Doctor Fanale had held the same position that Doctor Fallon holds now, correct?
A. I think his title was chief medical officer.
Q. Now, what sorts of physicians are part of the Physician Advisory Council?
A. Say that again. What source --

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Q. Yeah, what types of physicians? In other words, are these all doctors from a particular specialty? Are they from different specialties? What sort of doctors are there?
A. The doctors on this council are physician leaders in Massachusetts. They come from all different specialties.
Q. And when you say, "physician leaders," what are you referring to there?
A. Physicians who are leaders of their group or organization.
Q. I see. Do you mean by that that they are the heads of particular practices, or do you mean that they're physicians who are influential in their field?
A. Can be both.
Q. Is the criteria for membership on the council leadership of a large practice or influence in the field, or can it be either?
MR. COCO: Objection.
A. Well, there's no membership per se, so there is no membership. It's -- they're asked to

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sit on it, and they can be either. They can either be head of a group -- I wouldn't use the word "influential." I would just say respected by their peers.
Q. Who makes a decision as to what doctors should be invited to participate in the Physician Advisory Council?
A. The council -- it's a meeting held by the senior physician executive at Blue Cross Blue Shield of Mass. So, it would be that individual. But I know that they also get recommendations from probably some of their medical directors, I would imagine.
Q. Is the ultimate decision Doctor Fallon's as to who should be invited to sit on the council?
MR. COCO: Objection.
A. I don't know what -- I don't know who makes the ultimate decision.
Q. Now, meetings are held -- did you say three times a year -- of the Physician Advisory Council?
A. I think so.

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Q. Do you participate in any of those meetings?
A. I have attended.
Q. Have you attended all meetings in the recent past or just a few?
A. Define "recent past."
Q. Well, let's take the last two years to begin with.
A. I've attended probably most.
Q. For how many years would you say that's been your practice to attend most of the meetings?
A. Again, in my role, I'm responsible for the physician network. So, if these meetings have occurred and I've been in town or able to attend, I've attended.
Q. Would that be true for the full 15-year period that you've been at the company?
A. Not for the -- no, I haven't had the same role for all 15 years, so --
Q. Okay. I'm just trying to get a sense for how long this has been your practice to attend as many meetings as you can with your schedule.

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A. For many years, I couldn't give you --
Q. Sure. Are we talking about between one and three years, or are we talking about between ten and 12 years? I'm just trying to get a ballpark sense.
A. Ten years would be a good ballpark.
Q. Now, what are the sorts of issues that are discussed at the Physician Advisory Council meetings?
A. Typically, these meetings are essentially a way for the plan to have a dialog with physicians. So, they could be wide ranging, just current events, updates on what's happening at Blue Cross. In recent years, they've been more clinically focused. You know, best practices in certain types of treatments and conditions and things like that. It's not a -- that's essentially it.
Q. Okay. What issues are discussed other than clinical concerns?
A. If we're going to launch a new product, we'll probably get their feedback on stuff like

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that.
Q. By "new product," are you referring to a new health insurance plan?
A. A new product offering by the plan to employers, correct.
Q. Why -- why is that something that BCBS of Massachusetts would discuss with physicians, as opposed to potential clients?
MR. COCO: Objection.
A. We have those conversations with all constituencies. They'll have them with accounts with potential employers. Physicians are our constituent base, and we -- this group is -- we will try to let them know what the market looks like, what's coming down the road from our perspective just so that we can essentially give them some idea of what they might see from us.
Q. Now, is there any discussion in the Physician Advisory Council or its predecessors about reimbursement issues?
MR. COCO: Objection.
A. Reimbursement issues, I'd say no. I

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mean, based on the mix of physicians in the room, it would be tough to have those conversations.
Q. In the late 1990s, BCBS of Massachusetts moved from reimbursing drugs administered at physicians' offices at 100 percent of AWP to 95 percent of AWP, right?
A. I don't know when that occurred.
Q. Okay.
A. My understanding is it was AWP minus 5 percent.
Q. You're aware of fact that there was a shift in reimbursement from AWP to AWP minus 5 percent.
A. Yes.
Q. Now, was there any discussion of that issue in Physician Advisory Council meetings?
A. I don't know. Not that I can recall.
Q. More recently, BCBS of Massachusetts contemplated shifting from an AWP-based methodology to an ASP-based methodology. You're familiar with that, correct?
A. I'm aware of that.

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Q. Was there any discussion of that issue in Physician Advisory Council meetings?
A. No.
Q. Has there ever been discussion in a Physician Advisory Council meeting around the issue of physicians' acquisition costs for drugs?
A. No.
Q. Has there ever been discussion in Physician Advisory Council meetings around the issue of physician margins?
A. No.
Q. What do you understand the term "physician margins" to mean?
A. Taken at its face, a physician margin, essentially, profit.
Q. A distinction between what their costs are and what their reimbursement is.
MR. COCO: Objection.
Q. To the extent that's profit.
MR. COCO: Objection.
A. Well, I wouldn't -- again, to me, if you say a margin, to me, margin means profit.

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Q. Okay. Well, let's focus on drugs that are administered by physicians in their offices. You understand, of course, that physicians acquire those drugs, administer them to patients, and then seek reimbursement from payers, right?
A. Yes.
Q. Now, in relation to those -- well, are you familiar with the term "buy and bill"?
A. No.
Q. Okay. Well, in relation to the types of arrangements that we just discussed where a physician buys a drug, administers it, and then seeks reimbursement, do you have an understanding of how the term "margin" is used referring to a physician with that type of a practice?
MR. COCO: Objection.
A. I don't have those conversations with physicians. I may have heard it in the industry, but I'm not -- I've not used it, and it's not conversations that, in my role, I would have with a physician.
Q. Okay. What have you heard in the

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industry around that issue?
MR. COCO: Objection.
A. On that issue?
Q. Uh-huh.
A. Nothing. Just I've heard the term "margin" used.
Q. My question is, have you heard the term "margin" used in the context I just described?
MR. COCO: Objection.
A. No.
Q. What did you mean then when you said, I've heard about that in the industry?
A. Just physicians talk about just -- like any business talks about a margin and needing to pay their overhead and margin, profit.
Q. As the -- your current title is director of the provider relations department, is that correct?
A. It's senior director of provider relations, communications, and eHealth.
Q. Senior director of provider relations, communications, and eHealth?

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A. Correct.
Q. Okay. Well, now, we were talking about the Physician Advisory Council. Other than the Physician Advisory Council, are there any other advisory boards, bodies, or committees that you're aware of that involve similar interactions, where physicians get together with people from BCBS of Massachusetts to discuss issues?
MR. COCO: Objection.
A. Specialty committees, groups of physicians that would meet with our medical directors in a similar vein, just to -- again, in a smaller group -- have conversations about similar issues.
Q. Now, is a specialty committee -- we were -- withdraw that. Were you there describing two different things, or is it the same thing? In other words, is a specialty committee a group of physicians who meet with the medical director?
A. Yes.
Q. Now, why is that called a specialty committee?

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A. Typically, it's a group of the same specialty recognized by the Mass. Medical Society as a specialty organization. These are not groups that we created. These are groups that exist. They meet with all payers, and we're another plan that these groups meet with.
Q. So, for example, it could be a group of oncologists or an organization of oncologists who could have meetings with medical directors. That would be a specialty committee meeting.
A. That could be a group.
Q. How often are specialty committee meetings held?
A. They're -- I'd classify them as ad hoc. They're not on a regularly-scheduled basis. They may occur quarterly. They may occur once a year. It depends on the size, and frankly, the committee's willingness to want to meet with the plan.
Q. Do you participate in any of those meetings?
A. I have.

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Q. What proportion of those meetings do you attend at the present time?
A. At the present time? None.
Q. Okay. But you've attended them in the past, is that correct?
A. I have.
Q. All right. In the last five years, could you estimate what proportion of specialty committee meetings you would have attended?
A. Very small. I've only attended a few meetings of the -- of a couple of different societies just to -- for my own, just to understand what some of the -- these are clinical. I mean, these are meetings to talk about clinical issues, and I just want to have an understanding or wanted to know what some of the issues were.
I also have a relationship with the Mass. Medical Society for the plan. So, again, I'm a liaison many times with the medical society. And so, in my role there, it would also be to understand what -- what the general business issues are.

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Q. Are there ever discussions in specialty committee meetings of issues other than purely clinical?
A. There may be. We discourage it. But they -- we can't stop people from having conversations. But this is not the forum to engage in those conversations. That's not what the forums are intended to be.
Q. Why do you disparage it?
A. Because we have -- we -- we're happy to have those conversations at an individual-physician level. If a physician has an issue that's other than a clinical issue, we'd rather deal with them directly.
When these committee meetings or these specialty societies are having meetings with us, we really like to keep those conversations more at the clinical level. But, again, we don't script them. We can't tell them what to say.
Q. Do you recall any specialty committee meetings where there was discussion of reimbursement issues?

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A. I -- I recall -- I recall a meeting or two where concepts were discussed, yes.
Q. Okay. What meetings and what concepts are you referring to there?
A. The meeting I was at was probably the specialty of clinical oncologists.
Q. Now, was the group of clinical oncologists you're referring to, did they go by a particular name or was it just a collection of oncologists?
A. No, the group was MASCO. Yeah, Massachusetts Association of something -- clinical. MASCO.
Q. Clinical oncologists, perhaps?
A. Yeah, probably right. Lots of acronyms in our business.
Q. When was this meeting that you're referring to?
A. I couldn't even give you the date. It was a few years ago.
Q. Within the last five years?
A. Within the last five years.

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Q. Within the last three years?
A. I couldn't tell you.
Q. What was the issue under discussion at this MASCO meeting?
A. Well, again, I think there were lots of issues being discussed. We had -- we had not previously met with this group, as I recall. And again, it's just part of wanting to have a dialog, really trying to understand what the issues were for clinical oncologists in our network.
The only issue that really came up that I can recall that really wasn't a pure clinical issue was, I think, the concept of trying to understand how Blue Cross Blue Shield of Massachusetts dealt with reimbursing drugs that had not come to market yet.
So, in other words, the issues that they were raising were when drugs were approved by the FDA but not yet had been assigned a code by CPT for a code, how should they instruct their colleagues to bill the plan? I seem to remember that really being the gist of the conversation.

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Q. What was the resolution of that issue?
A. As I recall, we built a process with the network where they could essentially bill those new what we call J-codes. They could just bill them to us in a classification called NOC Code, N-O-C. The NOC code essentially is a CPT code that essentially says, There's no code for this and I'm billing it. So they could -- they could bill that, along with a copy of -- probably a copy of the invoice. That's my understanding.
Q. Other than that particular issue, do you recall any other issues that have been discussed of specialty meetings that are not purely clinical?
A. Not that I can recall. Again, I didn't attend every meeting, but the meetings I was at, no.
Q. Do you receive minutes from specialty committee meetings?
MR. COCO: Objection.
A. I would receive minutes if I was there.
Q. Okay.

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A. If there were. I can't say that there were always minutes at every -- these were not -- these were not -- these weren't those -- these were meetings, I mean, if there were action items or things to be followed up, there would be notes taken at a meeting just so that parties in the room would know what was discussed and what the resolution was.
Q. Okay. What about the Physician Advisory Council meetings, are minutes kept at those meetings?
A. I don't know.
Q. Have you ever seen minutes from those meetings or notes from those meetings?
A. They're not -- I've not. They're not that type of meeting. It's not a meeting. It's a discussion. It's -- it's a dinner and conversation with -- it's not a meeting under Roberts Rules of Order. So, it's not that type of meeting.
Q. At the Physician Advisory Council meetings that you did attend -- by the way, are

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they all dinners?
A. Yes. In the past there may have been breakfast meetings, but typically, it's a meal and a meeting.
Q. Now, at the meetings that you do recall, how many people, approximately, were present?
A. They could -- ten, 15.
Q. And how many people -- how many of those ten to 15 people were employees of BCBS of Massachusetts?
A. Well, I would say ten to 15 were ex -- were not employees of Blue Cross Blue Shield. I'd say the attendees from Blue Cross Blue Shield typically would be myself, potentially people on my staff, and regional medical directors that worked for either the chief medical officer or the chief physician executive. So, there could be four, five, six.
Q. Who from your staff would -- I forget now how you defined typically versus frequently, but who would regularly attend those meetings from your staff?

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A. The only attendees would be my direct reports that were -- had regional responsibility. Again, it was an opportunity for them to interact with the physicians that they work with. So, there were four -- or there are four regional directors, and those are typically the ones who would attend.
Q. Lisa Gorman is one of those, right? She's one of the people in that position?
A. Lisa is, yes.
Q. Now, I'd like to ask you about your background. Can you tell me what your education is after high school, please.
A. Four years of college.
Q. What did you study in college?
A. I have a bachelor's of -- bachelor of science in communication and a double major in communication and psychology.
Q. Did you -- withdraw that. Do you have any formal educational qualifications after your bachelor's degree?
A. I've received certificates from a couple

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of different programs, just continuing education.
Q. What sort of programs have you taken as part of continuing education?
A. Northeastern University, health care management; Harvard, negotiation and conflict resolution. That's it. And then just industry, you know, seminars and training, things like that.
Q. The health care management course at Northeastern, when did you take that?
A. I don't know the year. It was in the '90s. I honestly don't know.
Q. Was that a weekend, a month? How long - -
A. No, it was a -- it was a year. It was a year.
Q. Was it full-time study or part-time?
A. No, it was a couple of evenings a week. And it's just a -- it's just a certificate. It was not a -- it's not a degree. It's not an associate's or anything like that.
Q. Okay. What were the issues that you studied there in that course?

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A. Very broad, just -- it was just how health plans were built. It was a lot of history, a lot of marketing, things like that.
Q. Did you study, for example, how managed care came about?
A. I guess, as part of the history, the history of managed care, sure.
Q. Did you study the move from indemnity or charge-based plans to where it's HMO-type plans and other managed care type plans?
A. Briefly. It really was -- the course was not -- it wasn't a beginner's course. It's assumed that you already have that knowledge. It was, again, more an opportunity to connect with other people in the industry and further your own knowledge. For me, it was taken more to get a better understanding of how the marketing side of health plans worked, how products were sold, and things like that.
Q. Did you study, as part of that course, the structure of the health care industry? For example, role of wholesalers, specialty

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distributors, PBMs, entities of that sort.
MR. COCO: Objection.
A. No. No.
Q. Did you study at all the distribution channel for drugs in the health care industry?
A. No.
Q. Now, you mentioned you've also taken a number of industry-specific courses. What sort of courses did you have in mind there?
A. Specific to what I do. It would be communication, business strategy, contract negotiation, things like that.
Q. Other than these skills courses, communication, negotiation, things like that --
A. Yeah.
Q. -- did you take any courses that involved substantive study of the health care industry?
A. No.
Q. When did you receive your bachelor's degree?
A. May of 1990.

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Q. And where did you get that qualification from?
A. University of Miami, Coral Gables, Florida.
Q. After graduating in 1990, what did you do next?
MR. COCO: Objection.
A. Lived with my parents like all college graduates. I don't know. I came north looking for work.
Q. Did you start working?
A. After a period of self realization, yes, I did.
Q. Where did you start working?
A. I think -- I don't know, I think my first job was at -- at the time, the prior Fleet - - prior BankBoston, so, BayBank. You know, just a low-paying -- low-paying job.
Q. And that was in 1990?
A. That was in -- that was probably the fall of 1990 --
Q. Okay.

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A. -- if I had to guess.
Q. How long did you work for the bank?
A. Not even a -- probably a year.
Q. What did you do next?
A. I then took at job at Bay State Health Care.
Q. So, that was around 1991?
A. That was in February of 1991.
Q. Now, Bay State Health Care is a health insurer, right?
A. It was. It was an HMO that was later acquired by Blue Cross Blue Shield.
Q. And it's -- withdraw that. What was your initial role at Bay State Health Care?
A. I was hired in the claims department. I reviewed hospital claims.
Q. What sort of issues were you reviewing in terms of those hospital claims?
A. I literally was just a -- I would review fields on the claim form, make sure they were submitted. Essentially, that was it. It was just a claims reviewer and then kind of a quality

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assurance. So, when -- after the claims were keyed into our system, I would be responsible for going in and making sure that the claims were being processed.
Q. Were those inpatient claims, outpatient claims, or both?
A. Both.
Q. Was -- how was -- what methodology was Bay State Health Care using to reimburse hospitals for drugs that were administered to patients in that 1991 time frame?
MR. COCO: Objection.
A. I have no idea.
Q. When you saw the claim, did it reflect just a flat dollar sum?
A. I wouldn't -- the claims that I saw were billed on UB claim forms, and all I would really care to look at is what was the date of admission, what was the revenue code, and then make sure the fields were filled in. But at that part of my career I had no understanding of what the -- the detail was.

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Q. Okay. How long did you remain in the claims processing role?
A. Six months.
Q. Okay. What was the next position that you moved to?
A. I would have brought a copy of my resume. I think the next position I had, I then left to go into what was then called "professional relations" as a coordinator. So, essentially, that was where I began my career working with physicians.
Q. And that was in the fall of '91?
A. Well, six months after that. So, probably -- I think I actually landed in that role -- it was probably by then 1992. So, whatever that -- not exactly sure of the time frames, but --
Q. Okay. Somewhere in the '91, '92 period?
A. Yeah. Yeah.
Q. Now, how long did you remain in the professional relations coordinator role?
A. I was probably a coordinator for a

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couple of years, just responsible for taking phone calls and assisting what we called provider representatives. So, individuals from our company that would go out and meet with physicians. Again, I was kind of an internally-based person. And then I stayed in that role for probably a couple of years, and then I later took a job as the external provider relations representative.
Q. Now, when you were in the coordinator role, were you taking calls only from the field reps or also from physicians directly?
A. No, I took calls from physicians directly. I was the person they called if they had an issue or things like that.
Q. Now, while you were in that role, BCBS of Massachusetts acquired Bay State Health Care, is that correct?
A. That's correct.
Q. When was that acquisition?
A. I think it was October of 1992.
Q. Now, Bay State Health Care also had a staff model HMO in the early '90s, is that

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correct?
MR. COCO: Objection.
A. No, I don't think -- I don't think we did.
Q. Do you understand what I mean when I use the term "staff model HMO"?
A. I do.
Q. What is your understanding of that term?
A. A group of employed physicians that were owned and operated by the health plan, but I don't -- our Bay State did not -- to my knowledge -- didn't own or employ physicians and did not have a clinic-based practice.
Q. Are you aware that other witnesses have testified that Bay State did, indeed, have a staff model HMO in the early '90s?
MR. COCO: Objection.
A. I'm not aware that they have.
Q. Well --
A. In my role, again, if there was, I had no involvement with it. So, my understanding is that there wasn't.

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Q. Is it possible that there was a staff model HMO and you weren't aware of it?
MR. COCO: Objection.
A. No.
Q. So, you're absolutely certain that there was no staff model HMO, and anyone who testified to the contrary is wrong?
MR. COCO: Objection.
A. They have reason to obviously give you testimony based on what they know. If you're asking me if Bay State had a staff model HMO, to the best of my knowledge, the answer is no.
Q. Now, did BCBS of Massachusetts acquire Bay State Health Care -- well, withdraw that. Are you familiar with an entity called "Bay State Health System"?
A. Yes.
Q. Okay.
A. No relation.
Q. What is Bay State Health System?
A. Bay State Health System is a health system in western Massachusetts -- Springfield --

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made up of several hospitals.
Q. How long has Bay State Health System been in existence, to your knowledge?
A. I have no idea.
Q. Now, is it a -- is it a group of hospitals only, or are there also physician practices involved with Bay State Health System?
A. Bay State Health System has -- has hospitals, and it also has a group called Bay State Affiliated Physicians Organization or a group called BAPO, and that is a group of physicians. They may have other holdings, but I don't know what they are.
Q. Was -- to your knowledge, was there ever an entity affiliated with Bay State Health Care known as Bay State Health Systems?
A. When you say -- what do you mean by "affiliated"?
Q. Well, connected in any way.
MR. COCO: Objection.
A. Not -- no, unless there was a contract with them as a provider. But again, as I said

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earlier, Bay State Health Care didn't own or operate physicians. It was not the model. We were not a staff model HMO similar to other staff models that were in existence at the time. I don't even think we had a contract with Bay State Health System even when I was there.
Q. When you were at Bay State Health Care?
A. Correct.
Q. Are you aware that in the early '90s, Bay State Health Care was purchasing drugs directly from drug manufacturers?
MR. COCO: Objection.
A. No.
Q. If Bay State did not have a staff model HMO, are there any other facets of Bay State Health Care's business that you're aware of, that would explain its purchases of drugs?
MR. COCO: Objection.
A. No. I wasn't -- I wasn't -- again, my role was pretty limited when I was working there. So, in my role in working with physicians, I had no knowledge or really understanding of that.

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Q. But you are able to state categorically that there was no staff model HMO.
MR. COCO: Objection.
A. Again, you're asking me -- my recollection is that there wasn't -- I had no dealings with an entity, and I don't recall that there was.
Q. Well, that's a little different from -- from what I had asked you earlier. I mean, let me rephrase the question to you so it's clear. Are you saying that you don't know if a staff model HMO -- there may have been one, there may not have been one, or are you saying that you know for a fact there was no staff model HMO?
MR. COCO: Objection.
Q. Which of those two is it?
MR. COCO: Objection.
A. I'm saying, from my perspective, there wasn't. Again, you're -- I'm going back to 1991.
Q. Uh-huh.
A. My understanding is that there wasn't.
Q. So, we were talking about your role as a

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professional relations coordinator at Bay State Health Care, '91 or '92 to '94. The calls that you were getting from physicians at that time, what sort of issues were they -- were they bringing to you?
A. Wide-ranging. I'd just say it was just essentially, did you pay my claim? Did you not? I need a contract. Essentially, anything that they -- we took all the calls that a physician could potentially have any question about the health plan. We were not in the claims department, so we typically did not take claims calls. But we would take calls -- just general calls about physician practices.
Q. Did you receive -- well, withdraw that. At the time you were at Bay State Health Care prior to its acquisition by BCBS of Massachusetts, did you ever gain an understanding as to what methodology Bay State used to reimburse physicians for drugs administered in their offices?
MR. COCO: Objection.
A. No.

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Q. Now, after BCBS of Massachusetts acquired Bay State Health Care in October of '92, did your title change?
A. I think -- yeah. Well, we went from professional relations to -- we had several department names. I think we were called "network development & management, network planning and development, provider relations." So -- but my role was essentially the same. I was a field representative responsible for working with physicians, and that then later expanded to be hospitals after the acquisition.
Q. Well, when did you go from being the coordinator taking calls to being a field representative?
A. Probably right around the acquisition. Right around there.
Q. So, sometime around --
A. Actually, it might have even been right before.
Q. Okay.
A. I don't remember. It was sometime in

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1992, '93 probably.
Q. And as a field rep, what sort of issues were you dealing with physicians on?
A. Largely administrative, largely administrative issues.
Q. What do you mean when you refer to "administrative issues"?
A. Can't get claims paid, need to enroll in a health plan, questions about benefits and eligibility, technology issues, things like that.
Q. How long did you remain a field rep?
A. Probably several years, then went from a provider representative to then being a network manager responsible for a large -- larger delivery-system-type providers, and that was probably in 1995, '96.
Q. When you -- when you say, "larger delivery-system providers," what are you referring to?
A. I took on responsibility for what was then Mass. General, Brigham & Women's -- it became Partners Health Care. So, I had responsibility

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for that. Again, just being that -- managing that relationship, if you will.
Q. Are you referring to hospitals now?
A. Physicians and hospitals.
Q. So, you had responsibility for hospitals, but also for physician practices unrelated to hospitals?
A. Correct.
Q. As a network manager, were you responsible for handling all aspects of the relationship with the entity?
MR. COCO: Objection.
A. Not all, not by far.
Q. Okay. What aspects of the relationship were you responsible for?
A. Again, it was just -- it was essentially -- customer relationship management is the term I would use. It was really working with them to get them enrolled, get them credentialed, be their interface to the plan, help them understand different issues, maybe what some of our clinical policies were. That was essentially it -- get

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involved in some of the contracting work at the time, and things like that; new product launches -- products that we were offering to employers.
Q. When was the first time that you became aware of the methodology used by BCBS of Massachusetts to reimburse physicians for drugs administered in office?
MR. COCO: Objection.
A. When was the first time? I don't even know. First time I ever heard the term "AWP" was probably in the late '90s.
Q. What was the context in which you first heard the term?
A. Again, I think it was just in, you know, How are physicians reimbursed for drugs? And once I understood what types of things they were and how they were, you know, what -- what they were, then, you know, I probably would have heard it in that context of, The reimbursement is AWP minus 5 percent.
Q. When you say you understood what they were, are you referring to what the terms of

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reimbursement were?
A. No, just the fact that, again, in my business, just working with physicians, if you work with enough physicians, sooner or later you'll bump into an oncologist, and sooner or later they will want to know what your methodology is for reimbursing injectable drugs, and that would then lead you to research it and understand that the methodology is AWP minus 5 percent.
Q. When you first became aware of the methodology that BCBS used, what was it?
A. I don't understand.
Q. In other words, when you first became aware of what methodology BCBS of Massachusetts used to reimburse physicians --
A. Uh-huh.
Q. -- for drugs administered in office, what was the formula in use at that time?
MR. COCO: Objection.
A. It was either AWP or AWP minus 5 percent. I don't remember. I don't remember which one it would have been.

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Q. Okay. But you're aware of fact that both of those methodologies have been used in the past.
A. Yes.
MR. COCO: We've been going about an hour. Is this a good time to break or --
MR. MANGI: Sure.
(Recess was taken.)
(Subpoena marked Exhibit Fox 001.)
Q. Now, Mr. Fox, let me show you a document. Please take a look at that document, and I'm going to draw your attention to a specific part of it. Have you ever seen this document before?
A. I think I have.
Q. Did you see this document in the course of preparing for your deposition today?
A. I have.
Q. I'd like you to turn to Page 12 of the document, please, which is listed "Deposition Topics," and ask you to review Nos. 2, 3, 7, and 8, which is on the next page.

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A. (Witness reviews document.) Okay.
Q. Now, are you knowledgeable regarding these four topics?
A. Yes.
Q. Do you understand that you've been designated by Blue Cross Blue Shield of Massachusetts to speak for it as a corporate representative on these four topics?
A. Yes, I do.
Q. Okay. We'll come back to those in a couple of minutes. Now, let me ask you about the methodologies that BCBS of Massachusetts has used over time to reimburse physicians for drugs administered in office. Now, we talked a bit earlier about what you knew at the time as you held different roles. Have you done anything to educate yourself about different reimbursement methodologies that BCBS of Massachusetts has used over time in preparation for your deposition?
A. Not in preparation for the deposition. I just -- I worked with these methodologies for a number of years, so I'm familiar with them.

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Q. Well, prior to the late '90s, you didn't know what the methodologies were, isn't that your testimony earlier today?
A. Prior to the late '90?
MR. COCO: Objection.
A. No, I don't think I said that.
Q. Okay. Let me try and parse the issue out a bit then. I believe you testified a bit earlier today that the first time you heard of AWP was in the late '90s.
A. That's correct.
Q. Prior to that time and hearing about AWP at that time, did you know what methodologies BCBS of Massachusetts was using to reimburse physicians for drugs administered in office?
A. The answer --
MR. COCO: Objection.
A. The answer to that question is no. But when you say, "methodologies," I'm thinking of payment methodologies, because that's what my area of expertise is, and I'm very familiar with physician reimbursement methodologies. AWP --

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when you're talking about physician methodologies, AWP doesn't -- I'm not thinking AWP when you say that.
Q. Okay. Let's explore that a bit. What are you referring to when you use the term "payment methodology"?
MR. COCO: Objection.
A. The manner in which Blue Cross reimburses physicians.
Q. Okay. Well, let me ask you this: At the present time how is the amount that Blue Cross Blue Shield of Massachusetts reimburses physicians determined?
MR. COCO: Objection.
A. How is it determined?
Q. Yeah. How is the amount set?
A. Well, we use a -- for physician reimbursement, we start with an RBRVS-based methodology, which is methodology set by CMS. We then take that methodology and determine how we want to use that, essentially, and we'll reimburse physicians essentially using that methodology, but

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we don't pay the Medicare rates. We set our own payments based on that methodology, and we reimburse physicians accordingly. But we've used RBRVS-based reimbursement since 1995.
Q. Now, when you're referring to the RBRVS methodology, you're referring there to reimbursement to physicians for services that they render in treating patients, right?
A. That's correct.
Q. Now, that methodology has been in use at BCBS of Massachusetts since 1995?
A. '94, '95. But '95, I believe, is when we started using it.
Q. From 1995 up until 2005, did BCBS of Massachusetts reimburse for services -- withdraw that. From 1995 to 2005, did BCBS reimburse physicians for services rendered in treating patients in office at the same rate as Medicare or at a different rate?
MR. COCO: Objection.
A. At the same rate as Medicare?
Physicians services, no, not at the same rate.

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The same methodology, but not the same rate.
Q. In other words, you used the RBRVS methodology in calculating the rates, but the dollar sums that BCBS of Massachusetts paid were different from the dollar sums that Medicare paid.
MR. COCO: Objection.
A. In most instances, yes. In some instances, we actually may have carried forward some Medicare -- there may be services where it was appropriate to pay Medicare, and so, we made a decision to carry some of those rates forward. I don't -- I don't know specifically what, but not every case is different from Medicare.
Q. So, in most cases, BCBS of Massachusetts set its own rate, but using the RBRVS methodology.
MR. COCO: Objection.
A. Using the methodology. Remember, the methodology is essentially creating buckets of services and applying and doing -- doing lots of things that we can't do as a local health plan. So, in that instance, yes.
Q. Now, how did -- since 1995, how has BCBS

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of Massachusetts determined the actual dollar sums that it will pay physicians with respect to services they render in treating patients in their offices?
A. Well, each year we will -- we will look at what the -- we'll start with the Medicare reimbursement. What is the Medicare reimbursement? What is the calculations? What's the methodology?
We will then take a look at our mix of services, our utilization, based on the physicians in our network; we will take a look at the available pool of money which is available to adjust the fee schedule; we will let the RBRVS methodology apply. They apply all kinds of different factors to services; they weigh things; we will take that, and then we will come up with a disbursement model that we then calculate and communicate.
Q. Now, are there any other sources of information that factor into the process, other than what you just described?

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A. What do you mean by "sources of information"?
Q. Does BCBS collect input, solicit views from anyone in the market when performing this process, other than just internally looking at utilization and the pool of money and running a RBRVS schedule?
MR. COCO: Objection.
A. Collect, no. We don't collect -- no. We might look at CPI or DRI as kind of inflation factors, but we're not soliciting input. We're just -- we may collect that information as part of our due diligence.
Q. Okay. Other than CPI, are there any other indices or public sources of information that BCBS of Massachusetts utilizes in that process?
MR. COCO: Objection.
A. No.
Q. Now, are the -- or does BCBS of Massachusetts -- well, withdraw that. Since 1995, are you aware of any instances in which physicians

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have communicated to BCBS of Massachusetts their view as to whether or not the amounts they're reimbursed in relation to services rendered treating patients in office are adequate?
A. Am I aware? I mean, physicians always will communicate with the health plan to let them know they're not happy with reimbursement. Sure, that happens a lot.
Q. And that's nothing new. That's been true since at least the early '90s.
MR. COCO: Objection.
A. I can't say as to when it's been true. I can just tell you it's a -- it happens a lot.
Q. I'm asking based on your own experience. I picked the '90s because that's when you started working with providers. And has that been true throughout the period of time when you have been involved in working with providers, since 1992?
A. They're -- given the system of reimbursement that we have, there are going to be some physicians who do better than others. So, in years where some physicians do better, we probably

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won't hear from those physicians. And in some years when they don't do as well, we'll hear from those physicians as to being concerned about the rate of payment, sure.
Q. Now, are those concerns expressed by physicians one factor that BCBS of Massachusetts considers when determining the rates it's going to pay physicians for services that they render in treating patients in office?
MR. COCO: Objection.
A. I wouldn't say it's a factor. I would say it's a source of input. I wouldn't say it's a factor.
Q. Can you help me understand the distinction you're drawing between a source of input and a factor that's considered?
A. Sure. A physician calls and says, I'm not happy with my reimbursement. You take that in. That's input. That's a doctor telling you they're -- you know, if we have a large specialty group that comes to us and shows us errors in calculations, or if the national medical body

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comes back and says, We believe X and Y -- we worked with the OB/GYN physicians, for example, because of their malpractice issues.
They came to us as an organized group and said, Can you do something here, because our reimbursement rates are out of control compared to our malpractice rates?
We took that as a factor. So, I distinguish it being that was a factor in the decision we made to adjust the reimbursement made to OB/GYNs. Again, Medicare reimbursement doesn't really apply when you're talking about an OB/GYN physician. So, we -- I took -- I draw that as a distinction between a factor versus an individual doctor that calls and says, I'm not happy with my reimbursement.
Q. Well, when an individual doctor calls in with that sort of a concern, is it something that's given no consideration in the process of setting rates?
MR. COCO: Objection.
A. I wouldn't say it -- well, is it given